

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PAYMENTS FOR ENTERAL NUTRITION:  
MEDICARE AND OTHER PAYERS**



**JUNE GIBBS BROWN**  
Inspector General

MAY 1996  
OEI-03-94-00021

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# EXECUTIVE SUMMARY

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## PURPOSE

To assess the appropriateness of Medicare's reimbursement methodology for enteral nutrition products.

## BACKGROUND

Enteral nutrition products are usually liquid formulas that provide nourishment directly to the digestive tract of patients who cannot ingest an appropriate amount of calories to maintain the weight and strength commensurate with their overall health status. In 1994, the Medicare total allowed amount for enteral nutrition products and supplies was over \$680 million. For enteral nutrition products alone, the Medicare program allowed over \$330 million.

To assist in their evaluation and application of Medicare coverage and pricing policy, the Health Care Financing Administration (HCFA) requested the Office of Inspector General (OIG) to survey other payers about their enteral nutrition coverage and reimbursement policies. We previously reported on coverage policies in a separate report entitled *Coverage of Enteral Nutrition Therapy: Medicare and Other Payers (OEI-03-94-00020)*.

For the purposes of comparing pricing information, we surveyed other payers (health care insurers, Medicaid agencies, and the Department of Veterans Affairs) and retail pharmacies.

## FINDINGS

***For three enteral nutrition products, payers using competitive acquisition strategies reimbursed less than Medicare fee-for-service. Three traditional fee-for-service payers fared no better than Medicare in obtaining the best prices available.***

Six out of nine payers who provided detailed pricing information in our survey reimbursed less than Medicare fee-for-service for three enteral nutrition products: Ensure, Osmolite, and Glucerna. These payers reimbursed on average 48, 23, and 17 percent less than Medicare fee-for-service for these three respective products. Five of these payers negotiated contract prices with suppliers, taking advantage of discounts that can be achieved through competitive acquisition.

Unlike Medicare fee-for-service, most other payers we surveyed used competitive bidding or limited the number of contracted suppliers that could provide services to their members. The three payers who fared no better than Medicare in obtaining the best prices--a Blue Cross/Blue Shield plan using Medicare's fee schedule, and two State Medicaid agencies--did not utilize competitive acquisition.

***Retail pharmacies charge less than Medicare allows for two enteral nutrition products.***

Almost all of the retail pharmacies surveyed charged less than Medicare fee-for-service allowances for Ensure and Ensure Plus. Ninety-three percent of the retail pharmacies charged less than Medicare reimburses for Ensure. Ninety-eight percent of retail pharmacies in our survey charged less for Ensure Plus than Medicare allows. We surveyed pharmacies about their prices for these two products because they are the enteral nutrition products most commonly stocked in retail stores.

**RECOMMENDATION**

We believe that information from this report and a previous OIG report entitled *Payment for Enteral Nutrition Therapy Services Billed During Nursing Home Stays (OEI-06-92-00861)* raise concerns about the appropriate payment for enteral nutrition under Part B of the Medicare program.

Recommendations from our previous enteral nutrition report focused on Medicare reimbursement for beneficiaries living in nursing homes. However, we are also concerned that Medicare reimbursement for beneficiaries receiving enteral nutrition at home may not be appropriate. In light of the savings that could be achieved if Medicare re-evaluated its fee-for-service reimbursement policy for enteral nutrition, we recommend that HCFA consider one of the following.

- 1) **Reduce payments for enteral nutrition**, either across the board or for certain categories of enteral nutrition products.
- 2) **Use enteral nutrition as one of the first product types to acquire under new competitive acquisition strategies.** We understand that HCFA is planning a demonstration project involving competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies in Southern Florida, and has long sought the legislative authority to use such strategies for certain medical equipment and supplies. Through demonstrations or expanded legislative authority from the Congress, we suggest that HCFA use opportunities as they become available to acquire enteral nutrition products through competitive acquisition strategies.

**AGENCY COMMENTS**

Both HCFA and the Assistance Secretary for Planning and Evaluation concurred with our recommendation. The HCFA stated that currently the calculation for determining Medicare's payments for enteral nutrition products is mandated by legislation. However, HCFA reported that the President's Balanced Budget proposal includes provisions to freeze parental and enteral nutrition prices at 1993 levels until the year 2002. The proposal would also require the Secretary to competitively contract for certain services and supplies including enteral nutrients.

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# INTRODUCTION

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## PURPOSE

To assess the appropriateness of Medicare's reimbursement methodology for enteral nutrition products.

## BACKGROUND

*Medicare covers enteral nutrition products under the Part B prosthetic device benefit.*

Medicare Part B guidelines classify enteral nutrition under the prosthetic device benefit because coverage is limited to patients with a functioning gastrointestinal tract who have a permanent non-function or disease of the structures that normally permit food to reach the tract. Enteral nutrition products are usually liquid formulas that provide nourishment directly to the digestive tract of patients who cannot ingest an appropriate amount of calories to maintain the weight and strength commensurate with their overall health status. The three most common methods of administration for enteral nutrition products are: nasogastric tube inserted through the nostril, gastrostomy tube inserted through a surgical incision leading to the stomach, and jejunostomy tube inserted through a surgical incision leading to the small intestine.

*Medicare allowed over \$680 million dollars in enteral nutrition reimbursement in 1994.*

In 1994, the Medicare total allowed amount for enteral nutrition products and supplies was over \$680 million. For enteral nutrition products alone, the Medicare program allowed over \$330 million. Medicare's allowed amount includes the 80 percent that the Medicare program pays directly to the supplier and the 20 percent copayment for which the beneficiary is responsible.

The Health Care Financing Administration (HCFA) administers the Medicare Part B program. In October 1993, HCFA designated four Durable Medical Equipment Regional Carriers (DMERCs) to process claims for durable medical equipment, prosthetics, orthotics, and supplies, including enteral nutrition. Each DMERC is responsible for a specific region of the country and processes claims for Medicare beneficiaries residing in the region. The DMERCs are also responsible for issuing medical coverage policies that outline coverage and payment guidelines for covered services. The DMERCs have recently updated their enteral nutrition policies effective July 1, 1995.

To assist in their evaluation and application of Medicare coverage and pricing policy, HCFA requested the Office of Inspector General (OIG) to survey other payers about their enteral nutrition coverage and payment policies. An earlier OIG report, *Coverage of Enteral Nutrition Therapy: Medicare and Other Payers (OEI-03-94-00020)*, provided a comparison of Medicare coverage policies to those of other payers.

*Medicare classifies enteral nutrition products into different categories and reimburses based on those categories.*

Medicare classifies enteral nutrition products into six categories based on the composition and source of ingredients in each product. According to the DMERCs' policies, Category I semi-synthetic protein products are appropriate for the majority of patients requiring enteral nutrition. The guidelines state that if a physician prescribes a product from Categories III through VI, the medical necessity of these special product must be justified through documentation. If the request for a higher category product cannot be substantiated, payment is based on the allowance for the least costly alternative. For Categories I, II, III, and VI there is a single reimbursement amount for all the products that fall within each of the categories. In Categories IV and V, a specific price for each individual brand of product has been established. Medicare reimburses based on the units of enteral nutrition product used and defines a unit as 100 calories of enteral nutrition product. The categories of products, their composition, and Medicare reimbursement amounts are listed in Table 1.

**Table 1**

Product Category	Nutritional Composition	Medicare Allowance per 100 Calories
Category I	Semi-synthetic intact protein/protein isolates or Natural intact protein/protein isolate	.61  1.43
Category II	Intact protein/protein isolates (calorically dense)	.51
Category III	Hydrolyzed protein/amino acids	1.74
Category IV	Defined formulae for special metabolic need	varies by product
Category V	Modular components (protein, carbohydrates, fat)	varies by product
Category VI	Standardized Nutrients	1.24

## **METHODOLOGY**

For the purposes of comparing pricing information, we surveyed both Medicare and non-Medicare payers and retail pharmacies. We used Medicare's allowed amount for this comparison. The allowed amount includes the 80 percent the Medicare program pays directly to the supplier and the 20 percent copayment for which the beneficiary is responsible.



### *Survey of Payers*

Using a standardized data collection instrument, we obtained information on each payer's coverage and payment policies. We also asked respondents to provide specific prices for four enteral products. The four products were selected based on discussions with the DMERCs concerning the most frequently used enteral nutrition products by Medicare beneficiaries. Three of these products, Ensure, Jevity, and Osmolite are classified as Category I products by Medicare. The fourth, Glucerna, is considered a Category IV product. The information from payers was collected between September of 1994 and August of 1995.

We surveyed Medicare contractors to assess payment policies for beneficiaries under fee-for-service and managed care arrangements. The four DMERCs were surveyed as representatives of Medicare fee-for-service and five of the largest Medicare risk-contracted health maintenance organizations (HMOs) were selected as examples of Medicare managed care programs.

For our non-Medicare payers, we selected both fee-for-service and managed care payers. These payers were broken down into five groups. We selected the five largest payers from four of the five groups based on enrollment population. These four groups were: State Medicaid Agencies, Blue Cross/Blue Shield Associations (BC/BS), private HMOs, and private commercial/indemnity insurers. For the fifth group, we randomly selected five Department of Veterans Affairs (VA) facilities located in the same States as the Medicaid agencies in our sample.

We surveyed a total of 34 payers and received responses from 26. However, only nine respondents (other than the DMERCs) provided actual pricing information. Our analysis is based on the information from the payers listed in Table 2.

**Table 2**

<b>Type of Payer</b>	<b>Number of Respondents</b>
Medicare	
Durable Medical Equipment Regional Carriers	4
Medicare Risk-Contracted HMOs	4
Non-Medicare	
State Medicaid Agencies	5
Department of Veterans Affairs (VA) Facilities	4
Blue Cross/Blue Shield Associations	2
Private HMOs	4
Private Indemnity/Commercial Insurers	3

### *Survey of Retail Pharmacies*

Using a standardized data collection instrument, we contacted retail pharmacy stores in four States to determine their prices for two enteral products, Ensure and Ensure Plus. These two enteral nutrition products are the ones most commonly stocked by larger retail pharmacy chain stores. We purposefully selected four States (California, Florida, Montana, and Delaware) for which statewide information on pharmacies was available through our Office of Audit Services. For each State, we randomly selected 35 pharmacies. Ninety-six percent of the pharmacies in our survey (134 of 140) provided pricing information to us. The responding pharmacies were in a mix of both rural and urban areas with 27 percent located in rural areas. The survey information was collected in March of 1995.

This inspection was conducted as part of Operation Restore Trust (ORT). The initiative, focused in five States, involves multi-disciplinary teams of State and Federal personnel seeking to reduce fraud, waste, and abuse in nursing homes, hospices, home health agencies, and by durable medical equipment suppliers.

This inspection was performed in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

*For three enteral nutrition products, payers using competitive acquisition strategies reimbursed less than Medicare fee-for-service. Three traditional fee-for-service payers fared no better than Medicare in obtaining the best prices available.*

Six out of nine payers who provided detailed pricing information reimbursed less than Medicare fee-for-service for three enteral nutrition products: Ensure, Osmolite, and Glucerna. These payers reimbursed on average 48, 23, and 17 percent less than Medicare fee-for-service for these three respective products. For a fourth product, Jevity, six payers paid more than Medicare fee-for-service, one paid the same, and two paid less. The amount that each payer reimbursed for all four products is outlined in the table below. Ensure, Jevity, and Osmolite are Category I products for which the Medicare fee-for-service reimbursement rate is \$0.61 per 100 calories. Medicare allowances totalled \$244 million for Category I products in 1994. Glucerna is a Category IV product for which Medicare fee-for-service allows \$1.09 per 100 calories. Medicare allowed almost \$27 million for Glucerna in 1994.

**Table 3**

Type of Payer	Cost of Enteral Product Per 100 Calories			
	Ensure	Jevity	Osmolite	Glucerna
Medicare Fee-for-Service	\$0.61	\$0.61	\$0.61	\$1.09
Medicare Risk Contract HMOs	\$0.32 - 0.45	\$0.42 - 0.47	\$0.38 - 0.43	\$0.68 - 0.78
	\$0.21	\$0.65	\$0.58	\$0.84
	\$0.51 - 0.54	\$0.66 - 0.69	\$0.59 - 0.63	\$1.08 - 1.14
Medicaid States	\$0.52 <sup>1</sup>	\$0.65 <sup>1</sup>	\$0.58 <sup>1</sup>	\$1.07 <sup>1</sup>
	\$0.67	\$0.76	\$0.69	N/A <sup>2</sup>
	\$0.72	\$0.93	\$0.84	\$1.52
Veteran Affairs Acquisition Center	\$0.12	\$0.19	\$0.13 - 0.14	\$0.95
Blue Cross/Blue Shield	\$0.61	\$0.61	\$0.61	\$1.09
Private HMO	\$0.21	\$0.65	\$0.58	\$0.84

<sup>1</sup> This amount does not include the 5 to 10 percent manufacturer's drug rebate that this State receives.

<sup>2</sup> Paid based on the lesser of the billed amount, the Medicare fee schedule, or the expendable medical supplies acquisition fee.

Payers that negotiated contract prices with suppliers reimbursed less than Medicare fee-for-service. All five of the payers that negotiated contracts with suppliers had lower reimbursements for enteral nutrition products than Medicare fee-for-service. These payers took advantage of discounts that can be achieved through using a competitive acquisition strategy.

While the DMERCS provide reimbursement for Medicare fee-for-service based on an amount calculated using customary and prevailing charges, the Medicare risk-contracted HMOs differed considerably in their payment methodologies from Medicare fee-for-service. All three negotiated prices with suppliers or directly with the manufacturer. Two of the Medicare HMOs based this contracted price on an industry standard price such as AWP (average wholesale price) less a percentage of AWP (e.g., AWP - 10 percent). The AWP is a standard industry price that is usually the published suggested wholesale price obtained from the manufacturer of the product.

The Department of Veteran Affairs and the private HMO that reported reimbursement rates lower than Medicare fee-for-service also used contracted rates to reimburse for enteral nutrition products. Both the VA Acquisition Center and the HMO negotiate directly with manufacturers or suppliers to achieve the best price for these products.

Only one of the four fee-for-service payers, a Medicaid agency, reimbursed at a rate lower than Medicare fee-for-service. Another fee-for-service payer (a Blue Cross/Blue Shield plan) paid the same as Medicare fee-for-service since its reimbursement is based on the Medicare fee schedule. The remaining fee-for-service payers (two Medicaid agencies) reimbursed more than Medicare for enteral nutrition products.

The Medicaid payers used a number of payment strategies. For two Medicaid payers, they reimbursed the lesser of 1) the provider's usual and customary charge or 2) the wholesale acquisition cost (WAC) plus a standard percentage (7 or 50 percent). The acquisition cost represents the cost that the pharmacy or other type of supplier was charged when purchasing the product. In addition, one of these Medicaid States adds a pharmacist dispensing fee to this amount. This same State receives a drug rebate amount of 5 to 10 percent from the manufacturers of enteral nutrition products. The third Medicaid payer reimburses the lower of either AWP minus 5 percent or direct price and then adds a 50 percent mark-up.

***Unlike Medicare fee-for-service, most other payers used competitive acquisition to purchase enteral nutrition products or limited the number of suppliers who provided enteral nutrition products.***

Although only nine of the 22 non-Medicare fee-for-service payers provided dollar amounts for enteral nutrition reimbursement, other payers did provide their payment methodologies and delivery systems for enteral nutrition products. While we cannot assess whether their payment methodologies resulted in lower reimbursement prices

for enteral nutrition products, we did find many of these payers placed some kind of control on the purchasing or supplying of enteral nutrition products.

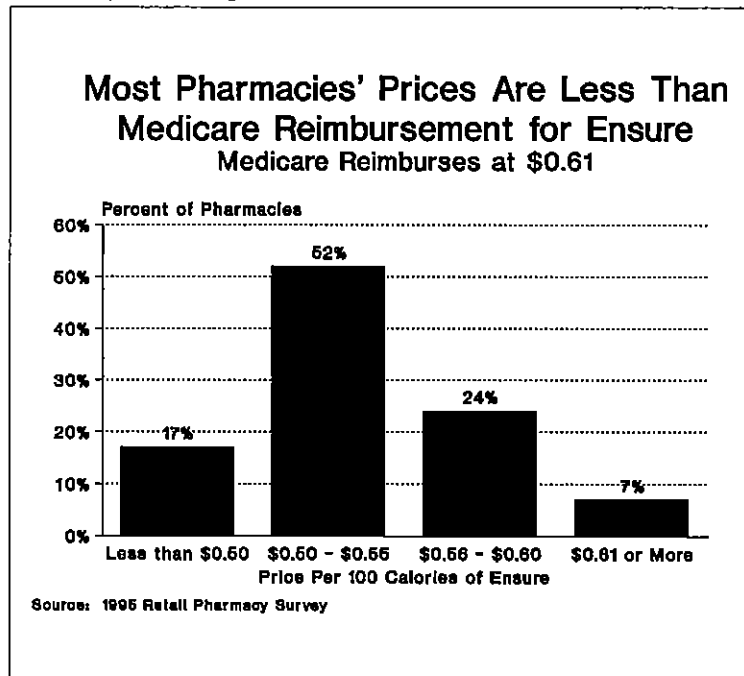
While both the DMERCs and Medicare risk-contracted HMOs provide reimbursement to suppliers under the Medicare program, all four risk-contracted HMOs limit whom they will reimburse as part of their managed care programs. The DMERCs allow the Medicare beneficiary to choose their own supplier, as long as the supplier is registered with the National Supplier Clearinghouse to provide service for Medicare reimbursement. In contrast, the Medicare risk-contracted HMOs limit their reimbursement to a smaller number of contracted suppliers or in-house pharmacies.

Except for Medicaid, most of the non-Medicare payers also limit their plan members to a few contracted suppliers. All four of the private HMOs contract with specific suppliers. One of these HMOs contracts with manufacturers and then provides enteral nutrition products through their in-house pharmacy and dietary service. Two of the commercial/indemnity payers use only contracted suppliers; the third will reimburse any supplier the plan member chooses under its indemnity plan. Local VA facilities provide enteral nutrition only through contracted suppliers or manufacturers. Both BC/BS payers have multiple contracted suppliers but one will also reimburse any supplier the plan member chooses. Unless recipients are enrolled in managed care plans, all but one of the Medicaid payers will reimburse any enrolled Medicaid provider for enteral nutrition products. The remaining Medicaid payer reimburses both contracted suppliers and any enrolled provider.

***Retail pharmacies charge less than Medicare allows for two enteral nutrition products.***

Almost all of the retail pharmacies surveyed charged less than Medicare fee-for-service reimbursement for Ensure and Ensure Plus. We surveyed pharmacies about their prices for these two products because they are the enteral nutrition products that would most likely be found in retail stores.

Ninety-three percent of the retail pharmacies charged less than Medicare reimburses for Ensure. The prices that pharmacies charged for Ensure are aggregated in the chart on the right. Ensure is a Category I product for which Medicare fee-for-service allows \$0.61 per 100 calories. Seventeen percent



of pharmacies charged at least 20 percent less than the \$0.61 that Medicare allows. More than half of all pharmacies (52 percent) charged between 10 and 20 percent less than Medicare reimburses.

Ninety-eight percent of retail pharmacies in our survey charged less for Ensure Plus than Medicare fee-for-service allows. Ensure Plus is classified by Medicare as a Category II enteral nutrition product and is reimbursed at \$0.51 per 100 calories. The

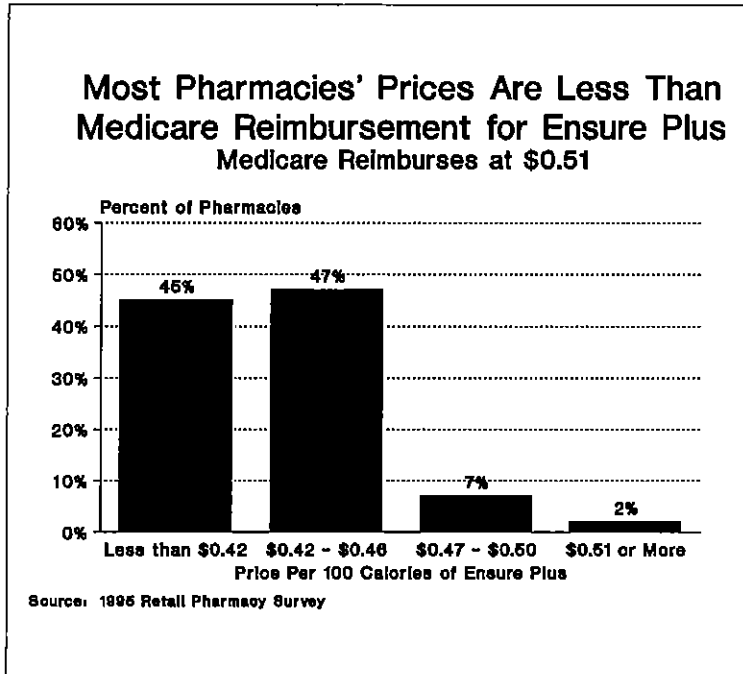


chart on the left summarizes the prices charged by retail pharmacies for Ensure Plus. Five percent of pharmacies charged at least 30 percent less for Ensure Plus than Medicare fee-for-service. Nearly 40 percent of pharmacies charged at least 20 percent below Medicare allowances. Almost half of the pharmacies surveyed (47 percent) charged between 10 and 20 percent less than Medicare reimburses.

In addition to these prices for single units of Ensure and Ensure Plus, 7 percent of pharmacies charge even less

when customers purchase in large volume such as cases of products. Also, 3 percent of pharmacies offered an additional discount to senior citizens.

# RECOMMENDATION

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We believe the payment practices detailed in this report fulfill HCFA's request for information on other payers' payment methodologies. In addition, we believe that information from this report and a previous OIG report entitled *Payment for Enteral Nutrition Therapy Services Billed During Nursing Home Stays (OEI-06-92-00861)* raise concerns about the appropriate payment for enteral nutrition under Part B of the Medicare program. Our findings, in this report, show that a consumer can walk into a retail pharmacy and purchase at least two enteral products at lower rates than Medicare fee-for-service allows for these products. We also found that other payers, including Medicare-contracted HMOs, reimburse less for enteral products than Medicare fee-for-service and that these lower payments are usually the result of negotiated contracts with suppliers of enteral nutrition products.

Recommendations from our previous enteral nutrition report focused on Medicare reimbursement for beneficiaries living in nursing homes. However, we are also concerned that Medicare reimbursement for beneficiaries receiving enteral nutrition at home may not be appropriate. In light of the savings that could be achieved if Medicare re-evaluated its fee-for-service reimbursement policy for enteral nutrition, we recommend that HCFA consider one of the following.

- 1) **Reduce payments for enteral nutrition**, either across the board or for certain categories of enteral nutrition products.
- 2) **Use enteral nutrition as one of the first product types to acquire under new competitive acquisition strategies.** We understand that HCFA is planning a demonstration project involving competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies in Southern Florida, and has long sought the legislative authority to use such strategies for certain medical equipment and supplies. Through demonstrations or expanded legislative authority from the Congress, we suggest that HCFA use opportunities as they become available to acquire enteral nutrition products through competitive acquisition strategies.

## AGENCY COMMENTS

Both HCFA and the Assistance Secretary for Planning and Evaluation concurred with our recommendation. The HCFA stated that currently the calculation for determining Medicare's payments for enteral nutrition products is mandated by legislation. However, HCFA reported that the President's Balanced Budget proposal includes provisions to freeze parental and enteral nutrition prices at 1993 levels until the year 2002. The proposal would also require the Secretary to competitively contract for certain services and supplies including enteral nutrients. The full text of HCFA's comments are provided in Appendix A.

# APPENDIX A

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## AGENCY COMMENTS





The Administrator  
Washington, D.C. 20201

**DATE:** FEB 20 1996

**TO:** June Gibbs Brown  
Inspector General

**FROM:** Bruce C. Vladeck  
Administrator

A handwritten signature in cursive script, appearing to read "Bruce C. Vladeck", is written over the typed name and title of the sender.

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Payment for Enteral Nutrition: Medicare and Other Payers," (OEI-03-94-00021)

We reviewed the subject report which contains information on Medicare pricing policies relative to enteral nutrition products. This report is supportive of the policy direction the Health Care Financing Administration has been pursuing.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments on  
Office of Inspector General (OIG) Draft Report  
“Payment for Enteral Nutrition: Medicare  
and Other Payers.”(OEI-03-94-00021)

OIG Recommendation

HCFA should reduce payments for enteral nutrition, either across the board or for certain categories of enteral nutrition products.

HCFA Response

We concur. As mandated by legislation, reimbursement for enteral products is based on reasonable charge pricing methodology rather than competitive acquisition strategies. This mandated price calculation does not permit such flexibility in pricing. However, the President’s Balanced Budget proposal includes provisions to freeze parenteral and enteral nutrition prices at 1993 levels until the year 2002. If this legislation is enacted, Medicare payments will decline relative to pharmacy prices.

OIG Recommendation

Use enteral nutrition as one of the first product types to acquire under new competitive acquisition strategies.

HCFA Response

We concur. HCFA has long sought legislative authority to use competitive bidding strategies for certain medical equipment and supplies. The President’s Balance Budget proposal includes provisions that would allow HCFA to use competitive acquisition strategies for these items. As described in section 11464 of the Bill, the Secretary would be required to competitively contract for certain services and supplies in a geographic area. Initial items would include enteral and parenteral nutrients, supplies and equipment, and MRIs and CAT scans. The Secretary could add other items in the future as appropriate. If the competitive bidding system did not result in a reduction of at least 15 percent in prices of selected services compared to calendar year 1997 levels, the Secretary would reduce fee schedule amounts sufficiently to achieve the 15 percent price discount.